

## Patient Safety Framework for Albertans

Provincial Framework  
September 2010

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## Acknowledgement

A proposal for the framework was developed by a working group of the Health Quality Council of Alberta. Members of the working group were drawn from Alberta Health Services, the College of Physicians and Surgeons of Alberta, the Alberta College of Pharmacists, the College and Association of Registered Nurses of Alberta, the Alberta Medical Association, a member of the public, a member from academia of health professions, and Alberta Health and Wellness.



## Foreword

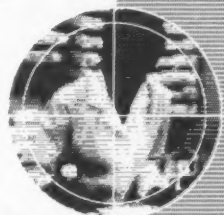
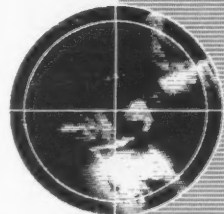
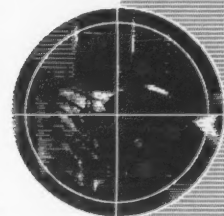
On behalf of the Health Quality Council of Alberta (HQCA) and members of the provincial Health Quality Network, I am pleased to introduce the *Patient Safety Framework for Albertans*. This foundational document was developed to guide, direct and support continuous and measurable improvement of patient safety in the province.

Each health care provider has a responsibility to deliver safe care. And every patient has the right to expect the safest care possible. For this to happen, we need to identify and accept basic principles of patient safety at the system level. This framework is an important collective step towards identifying and incorporating these principles to form the foundation of a safer health care system. The framework is based upon five building blocks or components and includes key strategies that contribute to strengthening Alberta's patient safety infrastructure. Together, these will facilitate and support an environment where the safest possible care can be delivered.

The framework is built on earlier work initiated by Alberta Health and Wellness. In 2009, the HQCA was asked to lead the final process to complete the framework. The HQCA had previously led development of two provincial frameworks – disclosure of harm to patients and families in 2006 and patient concerns/complaints resolution in 2007.

As with earlier frameworks, we consulted extensively with our stakeholders in developing the *Patient Safety Framework for Albertans*. Numerous drafts were reviewed by Alberta Health and Wellness, Alberta Health Services, the College of Physicians and Surgeons of Alberta, the Alberta College of Pharmacists, the College and Association of Registered Nurses of Alberta and the Alberta Medical Association as well as a public representative.

We also reviewed literature from provincial, national and international organizations to help crystallize concepts and ideas. The result is a framework that focuses on evidence-based practice and is relevant to patients, government, health care providers, management and boards and health profession regulatory colleges.







In helping to develop the *Patient Safety Framework for Albertans*, we benefited from the collaborative efforts of many organizations throughout the province that are committed to improving the quality and safety of our health care system. We acknowledge the valuable role these groups played in moving the quality and safety agenda forward.



Reaching consensus on an issue as fundamental and complex as patient safety is a daunting task.

We appreciate the support we have received from our partner organizations throughout the process. This framework would not have been possible without their expertise and input and we thank them for their time and dedication.

*John Cowell*

John W. Cowell, MD  
Chief Executive Officer  
Health Quality Council of Alberta  
September 2010

## Introduction

Albertans deserve a safe health care system that they can rely on whenever and wherever they receive health services. Alberta Health and Wellness pledges to build a strong foundation for the provision of safe care in the province.

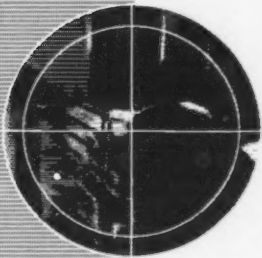
A patient safety framework has been developed to guide, direct and support the continuous and measurable improvement of patient safety in Alberta. The framework provides organizations and individuals providing health services with a comprehensive and systems-based approach to the provision of safe care based on fundamental principles of patient safety, which will remain relevant as the health care system continuously evolves. In order for Albertans to benefit from a safe health care system, it will be critical that health care boards, owners and proprietors as well as health professional regulatory councils embrace this framework and lead in the patient safety movement.

It is widely accepted that taking a proactive approach focused on redesigning systems of care will reduce the likelihood of occurrence of errors and adverse events. Health care workers in Alberta are well trained and highly competent. However, all humans are fallible and when they make errors, it rarely reflects the competence of the individual. Hence it is essential that the systems within which people work be designed to support them in delivering the safest care possible.

The provision of quality health care is considered according to the six dimensions of quality as defined in the *Alberta Quality Matrix for Health*<sup>1</sup>: acceptability, appropriateness, accessibility, effectiveness, efficiency and safety. This framework focuses on the provision of safe care within the context of quality where patient safety is understood to be the reduction of unsafe acts and use of leading practices that lead to optimal patient outcomes.

The framework narrative provides the necessary guiding and supportive information to understand the primary concepts of patient safety. The text boxes identify those action items that health care delivery organizations and regulated health professional colleges are expected to implement in order to build the foundation of patient safety. The strategies contextualize the primary tenets of the foundational elements and will develop tangible, measurable outcomes that will improve patient safety.

1 Alberta Quality Matrix for Health User Guide. [www.hqca.ca](http://www.hqca.ca)



## Key Principles of the Patient Safety Framework

While patient safety is not a new concept for caregivers and organizations providing health care services, knowledge of causes of errors and how they can be prevented has become more evident through studies of high risk, complex industries and organizations focused on improving the quality and safety of care provided in health care systems. Those studies have identified core safety principles and key safety concepts that have been incorporated into this patient safety framework. The framework identifies the following principles that organizations and health care providers will consider in the development of operational policies, procedures and performance review:

1. **Patients are the primary focus:** The patient is the centre of any health care plan or service. The patient is supported and encouraged to participate in his/her own care and his/her voice is heard in the planning, delivery and evaluation of health care services.
2. **Organizations create a patient safety culture:** Organizations build a patient safety culture by acknowledging that adverse events occur. They support those providing health care services, patients and the public to continuously search for ways to improve the systems of care that are at risk of failing, or have failed, to reduce the likelihood that patients are harmed. In a patient safety culture, individuals providing health care services feel free to express their concerns and to question issues that they believe are threats to patient safety in the care they are providing. So too, patients and their families willingly express their commendations and concerns about issues they perceive to be threats to patient safety in the care they are receiving. Both parties are empowered to speak out because there is evidence that their organization is paying attention and taking action.
3. **Information about adverse events is shared in a transparent manner:** By embracing transparency, leaders cultivate an environment where there are relationships between health care providers, patients and the public that are built on trust and open communication. Adverse events and close calls are reported and responded to in a transparent manner. Sharing information establishes trust and trust is essential for fostering collaboration at all levels.
4. **A systems approach is required to understand and address the complexity of factors that contribute to error:** The basic premise in the systems approach is that humans are fallible and errors are to be expected, even in the best organizations.<sup>2</sup> Errors are viewed as one factor contributing to patient harm but many other factors in the system also play a role. Systems can be made safer by designing them in a way to prevent errors, designing procedures to make errors visible when they occur so that they can be intercepted, and designing procedures for mitigating the adverse effects of errors when they are not detected or intercepted.<sup>3</sup>

2 Reason, J. Human error: models and management. *BMJ* 2000;320:768-770.

3 Nolan, T., System changes to improve patient safety. *BMJ* 2000;320:771-773.

5. **A continuous improvement approach strengthens an organization's ability to use new knowledge to make informed patient safety improvements:** Continuous improvement of structures and processes includes measuring, analyzing and reporting to develop new knowledge that informs improvement efforts. Leading practices are reviewed and applied to improve care. The risk of patients being harmed is reduced when organizations continuously examine and improve the way care is delivered, the skills and knowledge of the individuals providing care, the environment within which it is delivered, and the equipment used. Active involvement of patients as partners in their care strengthens and advances patient safety and is an important part of the continuous improvement process.

## The Building Blocks for Patient Safety

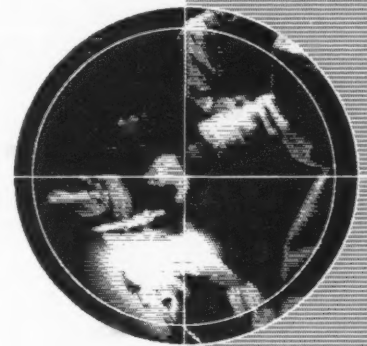
Because multiple factors contribute to adverse events, multiple system defences to reduce risk and promote a safer environment for patients are required. Broad systemic factors have been identified for promoting a systems approach to improving patient safety in the health care system. To enable organizations and individual health care providers to embrace and act upon the key principles, the patient safety framework is based upon the following building blocks: Governance and Leadership, Safety Management, People and Teams, Environment and Equipment, Patient Engagement.

### Governance and Leadership

Although patient safety is everyone's responsibility in health care, a safe system needs to start with leadership at the highest level. Government develops policy and establishes a legislative framework within which health care is delivered. It also sets standards and undertakes public assurance through system-wide monitoring and reporting. Government through legislation delegates responsibilities to others for the delivery of health services and to regulatory colleges for the licensing and credentialing of health professionals. Health professional regulatory colleges establish standards of practice that govern their registrants.

Boards, owners or proprietors of health care organizations also establish standards and operational policies that further define expectations about how services will be delivered safely and effectively. Standards between organizations, government and regulatory colleges are aligned, and the jurisdiction of each is clear.

While organizations and health professional regulatory colleges have key roles in patient safety, accountability for safe care depends on everyone from the patient to the government.





### **Support Structures and Systems for Patient Safety**

Support the implementation of structures and systems that ensure effective governance for patient safety based on strong reporting relationships, clear lines of accountability, and continuous monitoring and evaluation of organizational patient safety goals and objectives.

Boards and proprietors of health care services and councils of health profession regulatory colleges need to have an understanding of safety principles and current concepts to add context to their responsibilities and accountabilities in regard to patient safety in their governance role.

### **Demonstrate Patient Safety Is a Top Priority**

- Undertake education and training to understand the governance role related to risk management and the delivery of safe clinical care and health services.
- Consistently apply a patient safety lens to governance decisions.

Effective governance and leadership for patient safety is focused on:

- Making a visible commitment to patient safety as a clear priority.
- Supporting a patient safety culture.
- Ensuring processes are in place to determine that the right numbers and types of people, equipment and technology are available to maintain and improve patient safety.
- Supporting the development of a patient safety plan.
- Ensuring processes are in place to respond effectively to patient concerns.
- Ensuring that systems are in place to monitor, report and respond to patient safety issues.
- Evaluating the ability of the organization to provide safe care.

Culture is often described as “the way we do things around here”. To build a patient safety culture, health care organizations and regulatory agencies need to create a just and trusting environment in which people are encouraged and even rewarded for providing essential patient safety information. However, such a culture is not a “no blame” culture. In a just culture, a distinction is made between health care workers who commit unintentional errors as a result of systems issues and those who have failed to meet an acceptable professional standard of competence or conduct (e.g., reckless disregard

4 Reason, J. *Managing the Risks of Organizational Accidents*, 1997.



of procedures or wilful intent to harm). When health care workers feel safe to report hazardous situations, close calls and adverse events, even if they are involved as a result of committing an unintentional error, an opportunity is provided for understanding flaws in the system. Such understanding can ultimately lead to redesigning the structures and processes that support the delivery of safe care.

#### **Build a Patient Safety Culture**

- Establish a baseline measurement and conduct periodic assessments of their safety culture using validated instruments and processes.
- Create a just and trusting environment where those providing care and treatment are able to report safety issues and adverse events without fear of retribution, thus reducing the likelihood of repeated future adverse events.
- Create processes so all people engaged in the health system can be involved in working to reduce the risk of hazards and hazardous situations that cause harm to patients.
- Provide avenues for receiving and acting on commendations and concerns from patients, their families and the public about the quality of care received by patients and/or their families.
- Let patients and/or their families know that should a harmful event occur, they can expect open disclosure and ongoing communication, consistent with privacy legislation, while the event is reviewed.

Boards, operators of health care organizations and senior leaders are responsible for making decisions about the allocation of resources for patient safety management and for ensuring that all health care workers are educated, trained and empowered to improve patient safety. A patient safety plan is a means to inform and guide health care providers in understanding their organization's commitment and expectations for patient safety.

A patient safety plan serves as a road map for promoting the delivery of safe health care services by:

- Providing strong, clear and visible attention to patient safety.
- Requiring policies and procedures are in place for: a) the reporting of hazards or hazardous situations, close calls and adverse events, b) a system-based analysis to identify contributing factors that increase risk of harm to patients, and c) an evaluation of the impact of decisions and actions on patient outcomes.
- Having clear, measurable outcomes for patient safety; everyone in the organization knows his/her role in achieving those outcomes.

- Requiring patient safety education and training for board members, owners or proprietors of health care organizations, council members of health profession regulatory colleges, and all regulated and non-regulated health care workers.

Organizations have a responsibility to monitor risks to patient care and have appropriate reporting and response systems. When patients are seriously harmed by the health system, organizations have in place a critical path for managing and reporting the situation. Similarly, when adverse events result in less serious harm or a close call occurs, processes to document, manage and report the event are clearly understood by all those providing care and working in the organization.

Managing risks to patient care include the:

- Analysis of strategies to identify hazards and reduce risks associated with them.
- Assessment of feedback from effective patient commendation and complaint processes.
- Use of surveys to allow patients the opportunity to provide feedback, report hazards and hazardous situations, and rate their expectations and satisfaction with the health services received.
- Analysis of the quality of the treatments or care provided to patients.
- Analysis of the complications that occurred as a result of the care or treatments patients received.
- Appropriate review of health care workers' performance.

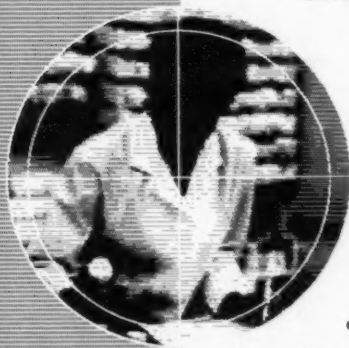
Meaningful and measurable indicators are used to measure the organization's performance in providing safe care. Standardized indicators allow for comparisons of health care outcomes among organizations for the purpose of learning and continuous improvement.

### Safety Management

Safety management involves four distinct elements: (1) proactive identification of risks to patient safety, (2) effective reactive response to adverse events and close calls when they do occur, (3) implementation of strategies based on the learnings from review of adverse events and their causes, and (4) evaluation of implemented recommendations.

Safety management begins with identifying potential hazards and hazardous situations that could harm patients and then prioritizing initiatives to reduce the risk of an adverse event occurring. Information about safe practices and processes is widely shared within an organization and between organizations to increase the likelihood that leading practices will be incorporated.

Organizations need to have the willingness and competence to draw the right conclusions from the patient safety information. They then need to implement system-wide improvements (processes and structures) designed to minimize the chances of future adverse events. Evaluation of the improvements



and continuous measurement of the effectiveness of health care processes provides information about whether the changes to health care delivery have achieved the desired results.

#### **Share Information about Patient Safety**

Health care organizations will share information within their environment and with other organizations on lessons learned about how to improve systems of care. This widespread sharing will increase the likelihood that leading practices supporting safe care will be incorporated across organizations and prevent similar events from happening in the future.

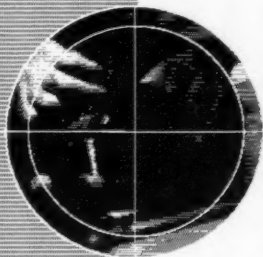
Despite attempts to prevent adverse events, unintended harm may still occur and the system needs to know how to respond. In such circumstances the first priority is to attend to the needs of the patient. Disclosure of the adverse event and additional follow up as more information becomes available is provided to the patient. In recognizing that harm may occur, the public needs to be informed and prepared for their role by providing them with information about potential harm, how they can assist management and other health care workers in avoiding risk, as well as what they can expect if they experience an adverse event. Health care workers, patients and their caregivers are actively involved and supported from the time a serious adverse event occurs until healing has had an opportunity to take place.

#### **Develop a Safety Management Plan**

A safety management plan will identify how an organization will:

- Monitor risks to patient care and utilize appropriate reporting and response systems.
- Provide education for all employees and those working in the organization on patient safety and adverse event response processes.
- Provide all employees and others working in the organization with a critical path for managing and reporting events when patients are seriously harmed by the health system or experience a close call.
- Outline a process to investigate an adverse event or close call in order to understand underlying factors and implement changes to reduce the chances of recurrence.
- Engage in accreditation processes to deliver safe patient care.





## People and Teams

A key element in providing safe patient care is having competent, supported health care workers working together in effective teams.

Competence is defined as the combination of knowledge, skill, attitude and judgment and begins with appropriate education and training. It requires ongoing continuing education programs that enable health care workers to remain current with changing practice standards, technologies and clinical information. The development and maintenance of competence is critical in an individual's chosen clinical field (e.g., medicine, nursing, pharmacy) and is equally important when dealing with issues of patient safety.

Health care workers who are members of a regulated health profession are held accountable by their regulatory colleges to practice according to professional standards of competence and conduct.

### Access to Information

- Regulatory colleges must have access to relevant information so they can undertake their legislated quality assurance responsibilities and proactively monitor the performance of their registrants.
- Health delivery organizations and health organizations with a legislative mandate for monitoring patient safety must have access to relevant information so that they can undertake their quality assurance responsibilities.

Health professional regulatory colleges (colleges) establish standards of practice for their regulated members and those regulated members are accountable to their regulatory colleges to comply with standards. Colleges should address the patient safety expectations that align with their standards of practice. Health care delivery organizations establish policies, procedures, and in some instances, additional standards. These standards should complement those of the colleges and must not be lesser than, or conflict with, those of the colleges. Employees and contracted services of a health care organization are governed by the internal policies and procedures of the organization, which must operate in compliance with federal and provincial legislation relative to its operation. Expectations of the employees or contracted services for their role in patient safety should be clearly expressed and reflected in the policies, procedures, standards, guidelines and contracts.

Organizations and health professional regulatory bodies both have a responsibility to monitor the performance of their registrants/ employees/contracted workers, and have a duty to share and communicate with one another in the interest of both quality and safety.

### **Collaboratively Monitor Compliance to Standards**

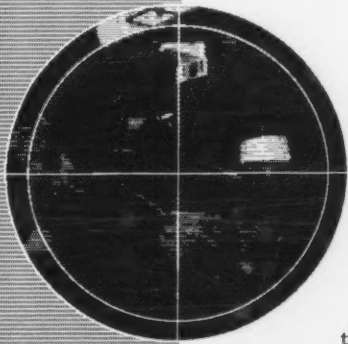
Health care delivery organizations will collaborate with health professional regulatory colleges to address system-based patient safety issues and the role and expectations of health care professionals in complying with standards of practice, organizational policies and procedures and guidelines. They will strive to develop a complementary role in sharing necessary information that promotes patient safety, enables regulated health professionals to practice according to standards set by their colleges, and recognizes organizational policies and procedures that reflect the needs and expectations of the organization in providing safe patient care.

On an ongoing basis, examination of the literature for leading practices will reveal new and leading processes and technologies that will require review and incorporation into current practices and relevant policies, procedures, standards and guidelines.

Health care is often delivered by teams of health care workers and includes the patient as an active participant. An effective team recognizes the unique contributions of each member, makes use of those contributions and accepts the responsibility of enhancing each member's skills, including those of the patient. Effective communication between teams and other health care providers is important for safe care of patients, especially when patients are transferred from one service to another. Health care workers need to be educated, trained and supported in these team practices, where applicable, throughout their careers.

The numbers and types of human resources required to provide safe and effective care need to be understood and meaningful ongoing efforts to recruit and retain competent health care workers are required. In addition to the people providing direct patient care and those who are in support positions, dedicated health care workers specially trained in patient safety processes are required to plan, implement and evaluate patient safety initiatives.

Patients have a vital role in patient safety and need to be included as members of the health care team. Supporting patients in their efforts to access health information will enable patients to be informed about their health condition(s) and proposed treatment(s). They are encouraged to ask questions about their care and choice of treatments.



## Environment and Equipment

Delivery of health care is complex and it is critical that the environment in which care is delivered is appropriately designed to support safe care. Fundamental to safe care is a physical plant that is subject to regular cleaning and disinfection standards and an environment that is designed and monitored for infection prevention and control and prevention of injuries. A healthy workforce is best positioned to provide safe health care. The health care provider should be supported by a healthy workplace that includes, but is not limited to, the following elements: design of physical space for patient safety, ergonomically sound work spaces, good air quality and proper lighting.

Regular testing and maintenance of equipment and purchase of user-friendly devices and supplies designed with patient safety in mind are key to providing patient safety. Equipment with built-in electronic warnings or physical barriers can alert health care providers of a potentially harmful situation and should be used where there is evidence that such equipment reduces risk. Adequate equipment resources should be available in a timely manner when required.

Health care organizations should use protocols and checklists in the use of equipment wisely and whenever possible. Protocols should be regularly updated to reflect changing knowledge and technology. Automated technology, that has been proven to improve the safety of patients, and new technologies that prevent risks associated with manual practices, should be carefully evaluated and implemented where feasible.

Simplification and standardization of key processes reduce the likelihood of error and the reliance on memory. This allows health care workers to use a process or piece of equipment safely and consistently.

Comprehensive real-time information systems help practitioners make clinical decisions about the care patients need. Information about the patient, medications, therapies, and treatment goals should be available wherever care is being delivered and shared with other health care workers who have a need to know. Data management standards ensure that the information entered is valid and complete, so outcomes of treatment can be measured and alerts to prevent complications or harm are provided.



## Patient Engagement

Patients are increasingly knowledgeable about health care delivery, want reassurance that their care is safe and effective, and seek opportunities to be active participants in the planning and decision-making process of system improvements for safety. They participate in diagnostic and treatment decisions about their health, and ensure they know what to expect from tests and treatment.

Patients can have a wider influence on improving their safety in health care. A culture of partnerships with patients can evolve from patients providing feedback on the impact of health services in their community or where they access services and identification of health care priorities to continuously improve patient safety.

### Active Patient Engagement

- Organizations will ensure that patients have opportunities to voice their concerns about the management of their conditions or outcomes at any time in the care process and that their voice is heard in a welcoming environment.
- Patients, or a public member representing patients, will be actively involved in meaningful consultation of health care planning and delivery.
- Boards will support other patient engagement strategies within the organization.

Boards, owners or proprietors of health care organizations can monitor the extent and effectiveness of patient involvement by reviewing:

- Evidence of patient involvement in assessment of service delivery.
- Changes resulting from concerns, complaints and feedback.
- The number of patients actively involved in strategic and service planning.
- Patient response to updated treatments and/or service information including rates of complications and outcomes of care.



## Strategic Initiatives

The *Patient Safety Framework for Albertans* provides long-term direction to improve patient safety in the health care system. In order to advance this framework, six strategic initiatives should be considered as priorities for action that will require strong leadership and synergistic collaboration between major stakeholders for effective outcomes.

To support safe care and understand an organization's performance in patient safety, organizations need to report adverse events, learn from them and take action to reduce the likelihood of their recurrence. Analysis of the events and their systemic causes will assist in informing new practices, developing strategies to mitigate risk and setting performance targets. Optimal learning will be supported by the interface of a provincial adverse event reporting and learning system with other provincial and national systems as they evolve.

### Strategy 1: Implement a Provincial Adverse Event Reporting and Learning System

A provincial reporting and learning system that will monitor and evaluate adverse events and close calls will facilitate learning from and acting on adverse events and close calls. Shared and widespread learning will reduce the likelihood of recurrence of adverse events.

Input from provincial leaders in patient safety is required to advise government on priority issues in patient safety. Currently, formal investigations of adverse events are undertaken through several different mechanisms including investigations conducted by properly appointed quality assurance committees as per Section 9 of the *Alberta Evidence Act*, as well as investigations through the *Public Health Act*, the *Health Care Protection Act*, the *Fatalities Inquiries Act*, the *Health Professions Act* and the Health Quality Council of Alberta Regulations under the *Regional Health Authorities Act*. Recommendations from these reviews and information from analysis of the provincial adverse event reporting and learning system can inform directional and operational policy changes to further enhance safe delivery of care in the province.

### **Strategy 2: Establish a Provincial Patient Safety Network**

A Provincial Patient Safety Network will be established under the leadership and direction of the Health Quality Council of Alberta, whose mandate is to promote and improve patient safety and health service quality on a provincewide basis. The network will identify strategies for systemic improvements and measurement of patient safety by:

- Sharing aggregate findings from investigations of adverse events that identify risks in the health care system and offer opportunities for improvement.
- Sharing relevant learnings from a provincial adverse event reporting and learning system.
- Reviewing the impact of health care policies on patient safety.
- Identifying research required to improve patient safety.
- Identifying barriers that limit effective learning from adverse events.

The Provincial Patient Safety Network will consist of experts from across the full spectrum of health care services with responsibility for patient safety, academics who are involved in the teaching of patient safety, personnel with legal and analytical expertise and the public.

Safety management plans built on a common model will facilitate communication among health care workers, the sharing of patient safety measures and risk reduction activities, and make transparent the health care organization's patient safety performance.

### **Strategy 3: Implement a Model of Safety Management**

A model to inform the development of a safety management plan will be undertaken by the leadership of the Health Quality Council of Alberta. The model will offer boards, owners and proprietors of health care organizations and health professional regulatory college councils information on leading practice methods to identify hazards/hazardous situations that could harm patients, developing a just and trusting culture, developing strategies to mitigate risk, evaluating system-wide improvements and sharing the learnings widely. The model will also identify key measures that reflect patient safety and provide guidance to organizations on how the measures can be used for ongoing safety improvement.



Policies and procedures, based on leading practices from a patient safety management model, comprise the critical infrastructure of a health care system to promote patient safety and prevent and manage adverse events.

**Strategy 4: Organizations Will Develop and Implement Operational Policies on a Just and Trusting Culture, Reporting and Learning from Adverse Events, Informing and Disclosure**

Organizations will have policies and procedures to support:

- A just and trusting culture that includes transparent communication.
- Reporting and learning from adverse events.
- Informing principal health partners and stakeholders.
- Disclosure to the patient and/or family when adverse events occur.

Health care workers require knowledge about patient safety principles and initiatives that support safe care. While all health care personnel should be knowledgeable about fundamental aspects of patient safety, education should be tailored to the level of knowledge required to perform the relevant responsibilities for patient care. A curriculum of patient safety education is needed to provide consistent information across the spectrum of health care.

**Strategy 5: Build Knowledge Capacity to Support Patient Safety**

A provincial curriculum for patient safety to build governance capacity to support patient safety will be developed. It will assist governing boards, owners or proprietors of health care organizations, and councils of health professional regulatory colleges in understanding patient safety and will support them in fulfilling their responsibility and accountability role to effectively monitor and evaluate safety in health care delivery. As well, the curriculum will educate future health care workers at the post-secondary level and the existing workforce about patient safety. This patient safety education curriculum will identify key patient safety learnings for different types of health care workers and leaders as well as provide tools for safe practice. The curriculum will be supported by the availability of relevant and practical educational resources.

A Provincial Patient Safety Advisory Panel made up of, but not limited to, patients and family members and representing the full scope of health care in Alberta would be of value in advising on broad, systemic issues of patient safety from a patient perspective. This panel would not address individual complaints about the health care system or facility-specific safety issues. Optimal learning and communication of safety issues would be enhanced through regular interfacing of this network with other provincial and national patient safety advisory groups.

**Strategy 6: Implement a Patient/Family Safety Advisory Panel**

A Patient/Family Safety Advisory Panel, with membership including but not limited to patients who have experienced harm as a result of health care services, will advise the Health Quality Council of Alberta (HQCA) of broad, systemic issues of patient safety from a patient perspective. The panel will be representative of the full scope of health care in Alberta and communicate to the HQCA safety strategies and approaches that will inform patients of their role in receiving safe care. It will report to the Council of the HQCA through its chief executive officer.

The above strategic initiatives reflect broad, system-based actions that will require a collaborative and long-term approach to building safer health care.

## Summary

The *Patient Safety Framework for Albertans* identifies direction for development of leading practice to build a safer health care system; however, knowledge is continuously evolving on safer processes that produce better patient outcomes. It will be necessary to keep abreast of the new information while demonstrating the key principles of the patient safety framework. Organizations and individuals providing health services are encouraged to keep the patient at the centre of any health care plan or service and take proactive steps to ensure safe systems.

When errors do occur, open and transparent communication about adverse events is critical to enable continued trust in the health care system. Widespread sharing of learnings from adverse events will strengthen the system and prevent recurrences of adverse events. A safer health care system is a realistic goal for all Albertans.



## Glossary

<b>Adverse Event</b>	An unexpected (unanticipated) outcome directly associated with the care provided that results in harm. ( <i>College of Physicians and Surgeons of Ontario</i> )
<b>Close Call</b>	An event or circumstance which has the potential to cause an adverse event but did not actualize due to chance, corrective action and/or timely intervention. ( <i>Canadian Council on Health Services Accreditation 2003</i> ). Also known as near miss or near hit.
<b>Disclosure</b>	The imparting, by health care workers to patients or their significant others, of information pertaining to any health care event affecting (or liable to affect) the patient's interests. ( <i>The Canadian Patient Safety Dictionary</i> )
<b>Harm</b>	An unexpected (unanticipated) or normally avoidable outcome that negatively affects a patient's health, quality of life, and occurs or has occurred during the course of receiving health care services. ( <i>Alberta Health Services – Calgary, adapted from College of Physicians and Surgeons of Ontario</i> )
<b>Hazard</b>	A set of circumstances or a situation that could harm a person's interests such as their health or welfare. ( <i>The Canadian Patient Safety Dictionary</i> )
<b>Human Error</b>	The failure to complete a planned action as it was intended, or when an incorrect plan is used in an attempt to achieve a given aim. ( <i>The Canadian Patient Safety Dictionary</i> )
<b>Human Factors</b>	The application of information about human behavior, abilities, capacities and limitations to the design of tools, systems, tasks and environments that result in safe, productive, comfortable and effective human use. (Sanders, MS. McCormick, EJ. <i>Illumination. Human Factors in Engineering and Design</i> . New York: McGraw-Hill; 1987. p. 408)
<b>Informing</b>	Communicating information about safety hazards, failures and fixes to principal health partners and stakeholders. ( <i>Calgary Health Region, Policy – Informing Principal Health Partners &amp; Stakeholders-Safety Hazards, Failures, Fixes, 2006</i> )
<b>Organizations</b>	All providers of health care services in Alberta.
<b>Patients</b>	People who directly or indirectly make use of health services.
<b>Patient Safety</b>	The reduction and mitigation of unsafe acts within the health care system, as well as through the use of best practices shown to lead to optimal patient outcomes. ( <i>The Canadian Patient Safety Dictionary</i> )

<b>Regulatory Colleges</b>	Organizations established under the <i>Health Professions Act</i> responsible for governing regulated health professionals. They develop standards of practice and codes of conduct, govern the licensure of their members and investigate/resolve registered member-related complaints. Examples include but are not limited to the College of Physicians and Surgeons of Alberta, the College and Association of Registered Nurses of Alberta and the Alberta College of Pharmacists.
<b>Reporting</b>	Documentation of hazards and situations where patients have suffered harm or experienced close calls.
<b>Risk</b>	The probability of danger, loss or injury within the health care system. ( <i>The Canadian Patient Safety Dictionary</i> )
<b>Risk Management</b>	Organizational activities designed to prevent patient injury or moderate the actual financial losses following an adverse outcome. ( <i>The Canadian Patient Safety Dictionary</i> )



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Promoting and improving patient safety and health service quality across Alberta

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